Genitourinary Medicine

This *Journal,* founded by the Medical Society for the Study of the Venereal Diseases, publishes original work on the investigation and treatment of venereal diseases, sexually transmitted diseases and allied disorders, and review articles, correspondence, and abstracts.

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(1) *Scripts* must be typewritten on one side of the paper only in double spacing with ample margins, and two copies should be sent.

(2) *Each script* should include, in the following order: a brief summary, typed on a separate sheet, outlining the main observations and conclusions; the text divided into appropriate sections; acknowledgements; tables, each on a separate sheet; and legends for illustrations.

(3) *The title* of the paper should be as brief as possible.

(4) *The number of authors* should be kept to the minimum, and only their initials and family names used.

(5) *Only the institution(s)* where work was done by each author should be stated.

(6) *SI units* are preferred. If old fashioned units are used SI units should be given in parentheses or, for tables and figures, a conversion factor given as a footnote.

(7) *Only recognised abbreviations* should be used.

(8) *Acknowledgements* should be limited to workers whose courtesy or help extended beyond their paid work, and supporting organisations.

(9) *Figures* should be numbered in the order in which they are first mentioned, referred to in the text, and provided with captions typed on a separate sheet. (*Diagrams:* use thick, white paper and insert lettering lightly in pencil. *Photographs:* should be marked on the back with the author's name and indicating the top edge. They should be trimmed to include only the relevant section (sizes 2¾" or 5¾" wide, maximum 5¾" × 7") to eliminate the need for reduction. Photomicrographs must have internal scale markers. *X* ray films should be submitted as photographic prints, carefully prepared so that they bring out the exact point to be illustrated.

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TABLE *Cultures positive for C trachomatis from CTA and ENT swabs from 294 women*

Cultures from	*No (%) positive*
Both swabs	35 (11·9)
CTA swab only	9 (3·1)
ENT swab only	6 (2·0)
Total	50 (17·0)

We found the new CTA swab to be at least comparable with the ENT swab for collecting specimens to culture *C trachomatis*. The CTA swab detected 88% of positive cases, while the ENT swab detected 82%. An added advantage for use of the CTA swab is its relative inexpensiveness, which is important to hospitals. We therefore feel that the CTA swab can be recommended for use in diagnosing chlamydial infections.

Yours faithfully,

*H Gnarpe**
G Andersson†
L Svensson†
*J Belsheim**
Departments of *Clinical Bacteriology and †Dermatovenerology,
Gävle Hospital, S-801 17 Gävle, Sweden

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1. Ripa KT. Biological principals of the cultivation of *Chlamydia trachomatis* in cell monolayers. In: *Chlamydia trachomatis in genital and related infection*. Uppsala, Sweden: Almqvist & Wiksell, 1982:25-9.
2. Mårdh PA, Zeeberg B. The toxic effect of sampling swabs and transportation tubes on the formation of intracytoplasmic inclusions of *Chlamydia trachomatis*. *British Journal of Venereal Diseases* 1981;**57**:268-72.
3. Kallings I, Mårdh P-A. Sampling and specimen handling in the diagnosis of genital *Chlamydia trachomatis* infections. In: *Chlamydia trachomatis in genital and related infection*. Uppsala, Sweden: Almqvist & Wiksell, 1982:21-4.

TO THE EDITOR, *Genitourinary Medicine*

Effect of epidemiological treatment of contacts in preventing recurrences of non-gonococcal urethritis

Sir,

The imaginative study by Fitzgerald (*British Journal of Venereal Diseases* 1984;**60**: 312-5) contains some fundamenal flaws in design and interpretation.

The apparently better results with prolonged (3 week) courses of tetracyclines (mostly triple tetracycline) could have been, and probably were, a manifestation of selection bias for compliance in this group. "Men were all offered three weeks treatment . . . but some defaulted before they had received the whole course." Those who defaulted formed the group taking short (1 to 2 week) courses. They were less compliant to treatment, and were therefore inherently less likely to respond for reasons other than the number of tablets they were given.

Comparison of treatment in 1978 with treatment in 1980 is also potentially erroneous. In this case, the results were similar and agreed with those of other workers, which makes it less likely that an error occurred. Nevertheless, a deterioration in response to tetracycline could have been masked by the epidemiological treatment of contacts and by a lower rate of reinfection.

Finally, when a difference is claimed it is surely mandatory to calculate the probability of this occurring by chance.

Yours faithfully

B A Evans
Department of Genitourinary Medicine, West London Hospital, London W6 7DQ

Notices

Second World Congress on Sexually Transmitted Diseases (STDs)

The 2nd world congress on sexually transmitted diseases (STDs) will be held at the Centre International de Congres de Paris (CIP), Porte Maillot, Paris, from 25 to 29 June 1986 under the patronage of the World Health Organisation and the International Union against Venereal Diseases and the Treponematoses. The general theme will be "STDs and their social and economic consequences".

Typewritten abstracts of papers should be submitted, in French or English, before 30 June 1985 to the Director, Dr A Siboulet, Institut Alfred Fournier, 25 boulevard Saint-Jacques, 75680 Paris, Cedex 14, France.

For further information concerning registration, travel arrangements, hotels, etc, please contact the Commissariat General, 4 Villa d'Orleans, 75014 Paris, France.

International meeting of dermatological research

The seventh meeting devoted to dermatological research will be held under the auspices of the Société de Recherche Dermatologique at Louvain University in Brussels on September 19 to 21, 1985. This meeting will be organised by the unit of occupational and environmental dermatology (director Professor J M Lachapelle).

Further information and application forms can be obtained from: Docteur D Van Neste, Unité de Dermatologie Professionnelle et de l'Environnement, Université Catholique de Louvain, UCL 3033, Clos Chapelle-aux-Champs, 30-B-1200 Bruxelles, Belgique.

Third International Forum of Andrology

The Third International Forum on Andrology will be held in Paris on 18 and 19 June, 1985. Topics for discussion will be: androgens (on the first day) and the epididymis (on the second day).

For further information please contact Professor G Arvis, Department of Urology, Hôpital Saint-Antoine, 184 rue du Faubourg-Saint-Antoine, 75571 Paris, Cedex 12, France.

Attention — new dates

Monday 17 and Tuesday 18 June.

List of current publications

These selected abstracts and titles from the world literature are arranged in the following sections:

Syphilis and other treponematoses

Transfusion syphilis, survival of *Treponema pallidum* in donor blood. 1. Report of an orientating study
JJ VAN DER SLUIS, PC ONVLEE, FCHA KOTHE, VD VUZEVSKI, GMN AELBERS, AND HE MENKE (Rotterdam, The Netherlands). *Vox Sang* 1984;**47**:197-204.

The value of routine rubella and syphilitic serology in the infertile couple
A LEADER, PJ TAYLOR, AND FA DAUDI (Calgary, Canada). *Fert Steril* 1984;**42**:140-2.

A method for evaluating the activity of antibiotics during the early phase of syphilitic infection
M POITEVIN AND P COLLART (Paris, France). *Pathol Biol (Paris)* 1984;**32**:576-80.

Gonorrhoea

Nonsexual transmission of gonorrhoea to a child
HJ LIPSITT AND A J PARMET (San Antonio, USA). *N Engl J Med* 1984;**311**:470.

Infections in sexual contacts and associates of children with gonorrhoea
WJ ALEXANDER, H GRIFFITH, JG HOUSCH, AND JR HOLMES (Birmingham, USA). *Sex Transm Dis* 1984;**11**:156-8.

A bacterial respiratory burst: stimulation of the metabolism of *Neisseria gonorrhoeae* by human serum
MS COHEN AND MJ COONEY (Chapel Hill, USA). *J Infect Dis* 1984;**150**:49-56.

Identification of an iron-regulated 37 000-dalton protein in the cell envelope of *Neisseria gonorrhoeae*
TA MIETZNER, GH LUGINBUHL, E SANDSTROM, AND SA MORSE (Atlanta, USA). *Infect Immun* 1984;**45**:410-6.

Influence of inoculum size on comparative susceptibilities of penicillinase-positive and -negative *Neisseria gonorrhoeae* to 31 antimicrobial agents
WH HALL AND BJ OPFER (Minneapolis, USA). *Antimicrob Agents Chemother* 1984;**26**:192-5.

Host-parasite interactions influencing establishment of gonococcal infection—a paradox resolved?
FP WINSTANLEY, CC BLACKWELL, DM WEIR, AND DF KINANE (Edinburgh, Scotland). *J Clin Lab Immunol* 1984;**14**:169-71.

Non specific genital infection and related disorders (chlamydial infections)

Chlamydial perihepatitis (Curtis-Fitz-Hugh-syndrome) after hydrotubation
JNL SIMSON (London, England). *Br Med J* 1984;**289**:544-5.

***Chlamydia trachomatis* is not an important cause of abnormal postcoital tests in ovulating patients**
DA BATTIN, RB BARNES, DI HOFFMAN, J SCHACHTER, GS diZEREGA, AND ML YONEKURA (Los Angeles, USA). *Fert Steril* 1984;**42**:233-6.

Sensitivity of detecting *Chlamydia trachomatis* elementary bodies in smears by use of a fluorescein labelled monoclonal antibody: comparison with conventional chlamydial isolation
BJ THOMAS, RT EVANS, DA HAWKINS, AND D TAYLOR-ROBINSON (Harrow, England). *J Clin Pathol* 1984;**37**:812-6.

Detection of *Chlamydia trachomatis* in genital specimens by the Chlamydiazyme test
MF JONES, TF SMITH, AJ HOUGLUM, AND JE HERRMANN (Rochester, USA). *J Clin Microbiol* 1984;**20**:465-7.

Chlamydial infection in Papanicolaou-stained cervical smears
RJ DE BORGES, O CARMONA, H MACHADO, AND J ESPARZA (Caracas, Venezuela). *Acta Cytol (Baltimore)* 1984;**28**:471-6.

Control mechanisms governing the infectivity of *Chlamydia trachomatis* for HeLa cells: mechanisms of endocytosis
ME WARD AND A MURRAY (Southampton, England). *J Gen Microbiol* 1984;**130**:1765-80.

In vitro tests of the adherence of *Chlamydia trachomatis* to human spermatozoa
P WØLNER-HANSSEN AND P-A MÅRDH (Seattle, USA). *Fertil Steril* 1984;**42:**102-7.

Activity of different antiseptics on *Chlamydia trachomatis*
D THOMAS, F ORFILA, AND E BISSAC (Amiens, France). *Pathol Biol (Paris)* 1984;**32:** 544-6.

Non specific genital infection and related disorders (mycoplasmal and ureaplasmal infections)

Microimmunofluorescence technique for detection of antibody to *Mycoplasma genitalium*
PM FURR AND D TAYLOR-ROBINSON (Harrow, England). *J Clin Pathol* 1984;**37:**1072-4.

Pelvic inflammatory disease

An assessment of the value of the menstrual history in differentiating acute appendicitis from pelvic inflammatory disease
JA ROBINSON AND BH BURCH (Saginaw, USA). *Surg Gynecol Obstet* 1984;**159:** 149-52.

Reiter's disease

Distal aortitis complicating Reiter's syndrome
SH MORGAN, RA ASHERSON, AND GRV HUGHES (London, England). *Br Heart J* 1984;**52:** 115-6.

Reiter's disease: successful treatment of skin manifestations with oral etretinate
D BENOLDI, A ALINOVI, G BIANCHI, AND G BUTICCHI (Parma, Italy). *Acta Derm Venereol (Stockh)* 1984;**64:**352-4.

Trichomoniasis

Can *Trichomonas vaginalis* cause pneumonia in newborn babies?
I HIEMSTRA, F VAN BEL, AND HM BERGER (Leiden, The Netherlands). *Br Med J* 1984;**289:**355-6.

Pathogenicity of *Trichomonas vaginalis:* cytopathologic and histopathologic changes of the cervical epithelium
BM HONIGBERG, PK GUPTA, MR SPENCE, *ET AL* (Amherst, USA). *Obstet Gynecol* 1984;**64:** 179-84.

Selective acquisition of plasma proteins by *Trichomonas vaginalis* and human lipoproteins as a growth requirement for this species
KM PETERSON AND JF ALDERETE (San Antonio, USA). *Mol Biochem Parasitol* 1984;**12:**37-48.

Candidosis

IgA and IgG antibodies to *Candida albicans* in the genital tract secretions of women with or without vaginal candidosis
PM GOUGH, DW WARNOCK, MD RICHARDSON, NJ MANSELL AND JM KING (Bristol, England). *Sabouraudia* 1984;**22:**265-71.

Magnesium and the regulation of germ-tube formation in *Candida albicans*
GM WALKER, PS SULLIVAN, AND MG SHEPHERD (Dunedin New Zealand). *J Gen Microbiol* 1984;**130:**1941-5.

Double-blind evaluation of ketoconazole comparatively with clotrimazole in vaginal candidiasis
A COMNINOS, I KAPELLAKIS, P PIKOULI-GIANNOPOULU AND TH MANAFI (Athens, Greece). *Current Therapeutic Research* 1984;**36:**100-4.

Comparison of itraconazole and ketoconazole in the treatment of experimental candidal vaginitis
JD SOBEL AND G MULLER (Philadelphia, USA). *Antimicrob Agents Chemother* 1984;**26:**266-7.

Genital herpes

Asymptomatic genital excretion of herpes simplex virus during early labor
GDV HANKINS, FG CUNNINGHAM, JP LUBY, SL BUTLER, J STROUD, AND M ROARK (Dallas, USA). *Am J Obstet Gynecol* 1984;**150:** 100-1.

Herpes simplex virus adsorption to and survival within placental lymphoid populations
RD ANDERSEN AND LI PIZER (Denver, USA). *Biol Neonate* 1984;**46:**110-4.

Evaluation of a commercial enzyme-linked immunosorbent assay for detection of herpes simplex virus antigen
AL WARFORD, RA LEVY, AND KA REKRUT (North Hollywood, USA). *J Clin Microbiol* 1984;**20:**490-3.

The effects of acyclovir on antibody response to herpes simplex virus in primary genital herpetic infections
DI BERNSTEIN, MA LOVETT, AND YJ BRYSON (Los Angeles, USA). *J Infect Dis* 1984; **150:**7-13.

The authors studied the antibody response in first episode herpes in patients who had no pre-existing antibodies to herpes simplex virus (HSV). Twelve patients were treated with acyclovir and nine with placebo. Serum samples obtained within six days of onset, 30 days, and six to 12 months later were tested by microneutralisation and western blot analysis (the methods are described in detail).

The results showed a reduction in the humoral response to HSV during the primary attack in the patients treated with acyclovir. They had a lower titre of type specific neutralising antibody, and a diminished response to individual polypeptides both in number and magnitude. This was most pronounced for polypeptides of 50-100 kilodaltons, corresponding to glycoproteins D and E of HSV.

The treated patients were significantly more likely to have a recurrence within the first 30 days, but recurrences over the six month follow up were no different. The antibody levels found when both groups were analysed six to 12 months after treatment were similar, so the consequences of the diminished early response remain undetermined. The authors also point out that

little is known about the importance of the variation in response to specific viral antigenic determinants.

M Fitzgerald

Genital warts

Presence of human papillomavirus in genital tumors

L GISSMANN, M BOSHART, M DÜRST, H IKENBERG, D WAGNER, AND HZ HAUSEN (Heidelberg, Federal Republic of Germany). *J Invest Dermatol* 1984; **83** suppl: 26s-8s.

Genital warts and cervical cancer. IV. A colposcopic index for differentiating subclinical papillomaviral infection from cervical intraepithelial neoplasia

R REID, CR STANHOPE, BR HERSCHMAN, CP CRUM, AND SJ AGRONOW (Detroit, USA). *Am J Obstet Gynecol* 1984; **149**: 815-23.

Acquired immune deficiency syndrome

Toxoplasmic encephalitis in patients with acquired immune deficiency syndrome

BJ LUFT, RG BROOKS, FK CONLEY, RE McCABE, AND JS REMINGTON (Palo Alto, USA). *JAMA* 1984; **252**: 913-7.

Non-Hodgkin's lymphoma in 90 homosexual men. Relation to generalized lymphadenopathy and the acquired immunodeficiency syndrome

JL ZIEGLER, JA BECKSTEAD, PA VOLBERDING, *ET AL* (San Franciso USA). *N Engl J Med* 1984; **311**: 565-70.

Hematologic abnormalities in the acquired immune deficiency syndrome

JL SPIVAK, BS BENDER, AND TC QUINN (Baltimore, USA). *Am J Med* 1984; **77**: 224-8.

Acquired immunodeficiency syndrome—an assessment of the present situation in the world: memorandum from a WHO meeting

Report of consultative meeting convened by WHO (Geneva, Switzerland). *Bull WHO* 1984; **62**: 419-32.

Prevalence of antibody to human T-lymphotropic virus type III in AIDS and AIDS-risk patients in Britain

R CHEINGSONG-POPOV, RA WEISS, A DALGLEISH, *ET AL* (London, England). *Lancet* 1984; ii: 477-80.

Two thousand people in the UK were screened serologically for antibodies to human T-lymphotropic virus type III (HTLV-III) using a competitive radioimmunoassay. This had already been shown to be wholly concordant with a membrane immunofluorescence assay to HTLV-III. Of 31 patients with the acquired immunodeficiency syndrome (AIDS), 30 were seropositive, the one negative patient having an unusual, remarkably benign form of the disease. Of patients with persistent generalised lymphadenopathy (PGL), 89% (110/124) had antibodies to HTLV-III as had 17% (53/308) asymptomatic homosexual men, 34% (63/184) haemophiliacs receiving pooled clotting factors, and only 1·5% (4/269) intravenous drug abusers. No blood donor out of 1042 screened was seropositive. The authors also found that serum samples reacting to the immunofluorescence assay for HTLV-III were also positive when tested against cells infected with lymphadenopathy associated virus (LAV-1) and concluded that HTLV-III and LAV-1 are indistinguishable and probably identical.

The distribution of seropositivity in the different groups is discussed emphasising the high level in haemophiliacs receiving pooled clotting factors compared with the absence of antibodies in indigenous blood donors and the low level in drug abusers who in Britain tend not to be homosexually active. The clinical and social significance of HTLV-III in AIDS and PGL is considered, though it is stressed that a test for anti-HTLV-III is not the same as a test for AIDS.

R S Pattman

Clinical findings and serological evidence of HTLV-III infection in homosexual contacts of patients with AIDS and persistent generalised lymphadenopathy in London

BG GAZZARD, DC SHANSON, C FARTHING, *ET AL* (London, England). *Lancet* 1984; ii: 480-3.

Oral candidiasis in high-risk patients as the initial manifestation of the acquired immunodeficiency syndrome

RS KLEIN, CA HARRIS, CB SMALL, B MOLL, M LESSER, AND GH FRIEDLAND (New York, USA). *N Engl J Med* 1984; **311**: 354-8.

In this paper the authors report on a prospective study to investigate whether patients who presented with unexplained oral candidiasis were in fact suffering from either the acquired immunodeficiency syndrome (AIDS) or the prodrome of this disease.

During September 1981 to July 1983, 22 patients with unexplained oral candidiasis were identified. None had clinical evidence of a serious opportunistic infection or neoplasm at entry into the study. Two additional groups of subjects were included for comparison: a group of 20 patients with documented AIDS, and a group of 20 patients who did not have oral candidiasis but who were thought to have the so-called AIDS related complex on the basis of unexplained generalised lymphadenopathy and reversed T4/T8 ratios. All patients were intravenous drug abusers, homosexual or bisexual men, or both.

Generalised lymphadenopathy was common in patients with unexplained oral candidiasis (20/22, 91%), as well as in those with AIDS related complex without candidiasis (20/20, 100%). Lymphopoenia (<1500 lymphocytes $\times 10^6/l$), which is present in all patients with AIDS, was present in 13/22 (62%) of patients with unexplained oral candidiasis, and in 11/20 (65%) of patients with AIDS related complex. All patients had T4/T8 ratios well below the normal range for the laboratory (1·1 to 3·6). Patients with AIDS had appreciably lower ratios than the other two groups. There was no pronounced difference between T4/T8 ratios of patients with oral candidiasis and those with AIDS related complex without candidiasis.

Of the 22 patients with unexplained oral candidiasis, 13 subsequently acquired life threatening opportunistic infections or Kaposi's sarcoma, which occurred one to 23 (mean three) months after candidiasis was diagnosed. Fifteen patients with unexplained oral candidiasis had T4/T8 ratios of $\leqslant 0{\cdot}50$. Twelve of these 15 patients went on to develop severe opportunistic infections or Kaposi's sarcoma. Of four patients with ratios of $\geqslant 0{\cdot}6$, none had developed AIDS after 4-19 (mean 10·5) months.

No patient with AIDS related complex without candidiasis had developed AIDS

after 5-21 (mean 12) months, although 9/20 of these patients had T4/T8 ratios of ⩽0·50.

In summary, this study suggests that, in people belonging to groups at high risk for AIDS, the presence of unexplained oral candidiasis and very low T4/T8 ratios indicated a high likelihood of the subsequent development of AIDS.

G R Scott

Ultrastructural markers of lymph nodes in patients with acquired immune deficiency syndrome and in homosexual males with unexplained persistent lymphadenopathy. A quantitative study

RM ONERHEIM, N WANG, N GILMORE, AND S JOTHY (Montreal, Canada). *Am J Clin Pathol* 1984; **82**: 280-8.

Follicular dendritic cells and virus-like particles in AIDS-related lymphadenopathy

JA ARMSTRONG AND R HORNE (Perth, Australia). *Lancet* 1984; ii: 370-2.

Defective polymorphonuclear leukocyte chemotaxis in homosexual men with persistent lymph node syndrome

FN VALONE, DG PAYAN, DI ABRAMS, AND EJ GOETZL (San Francisco, USA). *J Infect Dis* 1984; **150**: 267-71.

On the mechanism of thrombocytopenic purpura in sexually active homosexual men

CM WALSH, MA NARDI, AND S KARPATKIN (New York, USA). *N Engl J Med* 1984; **311**: 635-9.

Initial observations of the effect of radiotherapy on epidemic Kaposi's sarcoma

JS COOPER, PR FRIED, AND LJ LAUBENSTEIN (New York, USA). *JAMA* 1984; **252**: 934-5.

Prophylaxis of *Pneumocystis carinii* infection in AIDS with pyrimethamine-sulfadoxine

MS GOTTLIEB, S KNIGHT, R MITSUYASU, J WEISMAN, M ROTH, AND LS YOUNG (Los Angeles, USA). *Lancet* 1984; ii: 398-9.

Other sexually transmitted diseases

Extragenital granuloma inguinale (Donovanosis) diagnosed in the United Kingdom: a clinical, histological and electron microscopical study

DV SPAGNOLO, PR COBURN, JJ CREAM, AND BS AZADIAN (London, England). *J Clin Pathol* 1984; **37**: 945-9.

A 22 year old West Indian girl developed enlarging skin lesions in both axillae. The lesions spread to affect the adjacent chest wall and upper arms. She had no constitutional symptoms, and a course of ampicillin proved of no benefit. While visiting the UK one year after the lesions appeared, she sought a dermatological opinion. The lesions were described as extensive, raised, scaly, indurated plaques with an erythematous advancing edge. No ulceration was present. No genital or oral lesions were apparent, nor was there any local or distant lymphadenopathy.

The diagnosis was established by the presence of large histiocytes containing bacilliform organisms typical of Donovan bodies in Giemsa and silver stained fresh tissue smears from the third skin biopsy. Electron microscopy also showed the characteristic picture of granuloma inguinale, albeit that the intracellular organisms were scanty and rather degenerate in appearance. Fungal infection, tuberculosis, leishmaniasis, and syphilis were excluded. All three skin biopsies grew *Serratia marcescens*. There was no response to treatment with oxytetracycline, but cotrimoxazole brought about complete healing in 14 days with no scarring.

This discussion centred on the establishment of the diagnosis, an essential deliberation, considering the exceptional rarity of primary non-oral extragenital granuloma inguinale. Regrettably, clinical aspects of the case, notably the strongly atypical nature of the skin lesions and the possible source of the infection, were not discussed. Concomitant sexually transmitted diseases other than syphilis were not sought. The definitive diagnosis of granuloma inguinale rests upon histology, and this unusual case perhaps broadens the recognised range of this infection.

C Bignell

Efficacy of the condom as a barrier to the transmission of cytomegalovirus

S KATZNELSON, WL DREW, AND L MINTZ (San Francisco, USA). *J Infect Dis* 1984; **150**: 155-7.

Bacteremia caused by *Campylobacter*-like organisms in two male homosexuals

J PASTERNAK, R BOLIVAR, RL HOPFER, *ET AL* (Houston, USA). *Ann Intern Med* 1984; **101**: 339-41.

The prevalence of antibodies reactive with *Campylobacter jejuni* in the serum of homosexual men

A McMILLAN, GJC McNEILLAGE AND KC WATSON (Edinburgh, Scotland). *J Infect* 1984; **9**: 63-8.

Comparison of the sensitivity of microscopy and culture in the laboratory diagnosis of intestinal protozoal infection

A McMILLAN AND GJC McNEILLAGE (Edinburgh, Scotland). *J Clin Pathol* 1984; **37**: 809-11.

Hepatitis B vaccination: how long does protection last?

W JILG, M SCHMIDT, F DEINHARDT, AND R ZACHOVAL (Munich, Federal Republic of Germany). *Lancet* 1984; ii: 458.

Genitourinary bacteriology

Difficulties in quantitating the contribution of urethral bacteria to prostatic fluid and seminal fluid cultures

JE FOWLER AND M MARIANO (Charlottesville, USA). *J Urol* 1984; **132**: 471-3.

Localisation of bacterial infection of the prostate requires culture of sequential urine samples and expressed prostatic fluid (EPS) with or without semen culture, according to a well recognised method devised by Meares and Stamey. Bacterial infection of EPS is implied if the concentration of bacteria is greater than 10 times the concentration in the initial (VB1) urine sample. This quite useful test in Gram positive infections is less helpful when Gram negative organisms are cultured. The authors investigated six healthy men undergoing vasectomy who had no evidence of urinary tract disease and had not received antibiotics. Two men had coliforms in either EPS or semen with no evidence in any urine sample. The other men had two or more different Gram negative organisms found in the EPS or semen, some in more than 10 times concentration of the VB1, mid stream (VB2), or after massage (VB3) specimens. Concentrations of Gram negative bacteria in such

patients were similar in both VB1 and VB3 specimens. The authors suggest that, as no patient had increased numbers of leucocytes in any specimens and no symptomatic evidence of disease, these results indicate that contamination by urethral Gram negative organisms is more likely to occur in EPS or semen than urine samples. Interpretation and diagnosis of apparent Gram negative bacterial infection of urine and EPS is therefore more difficult than that with Gram positive bacteria.

P Simmons

Gardnerella vaginalis bacteremia: a review of thirty cases

LG REIMER AND LB RELLER (Denver, USA). *Obstet Gynecol* 1984;**64:**170-2.

Vaginal carriage and neonatal acquisition of _Clostridium difficile_

S TABAQCHALI, S O'FARRELL, JQ NASH, AND M WILKS (London, England). *J Med Microbiol* 1984;**18:**47-53.

Public health and social aspects

Prevalence of six sexually transmitted disease agents among pregnant inner-city adolescents and pregnancy outcome

PH HARDY, JB HARDY, EE NELL, DA GRAHAM, MR SPENCE, AND RC ROSENBAUM (Baltimore, USA). *Lancet* 1984;ii:333-7.

One hundred and fifteen girls aged 13-17 years from poor socioeconomic backgrounds were screened for six sexually transmitted agents by paired endocervical swabs during the third trimester of pregnancy. *Chlamydia trachomatis* was isolated from 39 (37%) of 105 (10 toxic specimens), *Trichomonas vaginalis* from 39 (34%), candida from 44 (38%), *Mycoplasma hominis* from 86 (75%), *Ureaplasma urealyticum* from 104 (90%), and *Neisseria gonorrhoeae* from only one patient.

The distribution of confounding factors, such as socioeconomic background, age, weight before pregnancy, weight gain, cigarette smoking, previous obstetric history, pre-eclampsia, and delivery by caesarean section, was not significantly different in the groups of patients with each infection. The very high frequencies of infection with *M hominis* and *U urealyticum,* and the very low rate for *N gonorrhoeae* precluded analysis of the effects of these agents.

A patient who harboured *M hominis* and *U urealyticum* had a stillbirth, but no obstetric cause was found. Cervical infections with *C trachomatis* and *Candida* spp alone had no effect on gestational age or birthweight. Infection with *T vaginalis* was noticeably associated with reduction in average gestational age at delivery and increased incidence of <2500 g birthweight. In the group of 11 patients harbouring *T vaginalis* and *C trachomatis* the average birthweight and the mean gestational age were lower than in any other group and the incidence of low birthweight was higher.

Six mothers had postpartum endometritis after caesarean section; all had been positive for *U urealyticum,* four for *M hominis,* two for *C trachomatis,* and one for *T vaginalis.*

Of 90 infants followed up for four months, seven of 11 with conjunctivitis had chlamydia positive mothers, as did one of four babies with pneumonia and seven of 25 with upper respiratory tract infection.

The high incidence of multiple sexually transmitted infections in these adolescents makes it difficult to assess relations between any single agent and pregnancy outcome; further investigations with larger numbers during the whole of pregnancy are indicated.

C Dixon

Social relevance of genital herpes simplex in children

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Miscellaneous

***Branhamella catarrhalis* (beta lactamase positive) opthalmia neonatorum**

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